



Dear Applicant:

Thank you for your interest in the Great Lakes Hemophilia Foundation (GLHF) Individual Class Scholarship. This scholarship is being offered to continue the Foundation's goal of improving the quality of life for individuals affected by blood disorders through career advancement and improved vocational opportunities.

Applicants can receive up to \$500.00 per class per scholarship period. All awards will be presented on behalf of the recipient directly to the institution where the class will take place. Repeat applications are welcomed. Previous recipients are considered at no advantage or disadvantage with other applicants.

The evaluation of each applicant will be based on achieving the long-term goals of the Scholarship Program:

- Improved patient and family access to insurance,
- Decreased dependency on public sources of support, and
- Increased commitment to the bleeding disorders community.

Applicants will be evaluated using a number of criteria including personal circumstances and financial need. Priority will be granted to individuals with bleeding disorders, then parents of children with bleeding disorders and then spouses of individuals with bleeding disorders.

In order to be considered for an award, applications must be received in the GLHF office. Faxed applications will not be accepted. **Incomplete applications will not be evaluated.** A complete application will consist of:

- completed Application Form
- Acceptance Letter from the program

Please send the application and all other materials to Great Lakes Hemophilia Foundation, 638 North 18th Street Suite 108, Milwaukee, WI 53201-0704.

We look forward to reviewing your application materials. Good luck to you! Please call 414-257-0200 or toll free at 888-797-4543 if you have any questions.

Sincerely,

Karin Daniels
Program Services Coordinator



INDIVIDUAL CLASS ASSISTANCE PROGRAM

Please TYPE or PRINT. Please thoroughly complete each question.
Previous applications will not be referenced.

I. PERSONAL INFORMATION: Please include your email address after your name.

1. Name _____

2. Address _____

3. City _____ WI, Zip Code _____

4. Phone () _____ 5. Date of Birth / / _____

6. Race/Ethnicity: African American Native American Arab American
 (Optional: for record keeping only) Asian American Caucasian Latin American
 Other: _____

7. Social Security Number: _____ - _____ - _____
 (For tax reporting purposes)

8. Type of Bleeding Disorder in Family (check the appropriate box and/or describe):
 a). Hemophilia: A B Severity: _____
 b). Other factor deficiency: _____
 c). von Willebrand disease, type: _____
 d). Carrier: Symptomatic Asymptomatic Factor Level: _____
 e). Other bleeding disorder: _____

9. Person(s) in my family with a bleeding disorder (check all that apply):
 myself my child my parent my brother or sister Other: _____

II. EDUCATIONAL INFORMATION:

1. State the class and school for which you are seeking assistance. Include a brief description of the class and how taking this class will assist you in your career/life.

2. Are you currently enrolled in this program? Yes No
 If no, Have you applied? Yes No
 Have you been accepted? Yes No (go to #5)
 Date you will begin: _____

3. If you have yet to be accepted into this program, when will a decision be made? _____

III. EMPLOYMENT INFORMATION:

1. List your current employment.

Employer:	Duties:	Dates Employed:	Hours Worked:

IV. FINANCIAL INFORMATION:

1. What is the anticipated cost of the class or training program for which you are seeking assistance?

Maximum award \$500.00

Tuition: \$ _____ Enrollment Fees: \$ _____ Total: \$ _____

2. What is your personal financial contribution to this class or program? \$ _____

3. How much assistance are you seeking from the Great Lakes Hemophilia Foundation? \$ _____

4. Have you applied for other GLHF scholarships for your education? Yes (go to 5a) No

5a. If **yes**, please complete the chart below.

Award Type	Amount of award	Date award received
	Total:	

5. Please indicate any other source of aid that will be used to support your education (i.e. trust fund, inheritance, etc.).

6. What are your/your family's annual out-of-pocket expenses for the treatment and care of the individual(s) with a bleeding disorder?

Factor: \$ _____ Insurance Premiums: \$ _____ Medications: \$ _____ Other: \$ _____

7. Please check the statement that applies, and fill in the information requested. This information will help us estimate your/your family's level of financial need.

I am:

- supporting myself.
My annual income is \$ _____.
- supporting my family.
The annual family income is \$ _____; family size is _____.

8. Please identify any extenuating financial circumstances that may further explain your/your family's financial situation. Please attach a separate sheet if necessary.

V. SUPPORTING MATERIAL:

1. If you are not currently enrolled in the class or training program for which you are seeking assistance, please also attach a copy of an **ACCEPTANCE LETTER FROM THE PROGRAM**. Confirmation of acceptance into your chosen program of study must be received before a decision can be made regarding your eligibility for an Education and Training Assistance Program scholarship.

VI. DECLARATION OF APPLICANT

I, _____, certify that the information I have submitted is true and accurate to the best of my knowledge. In the event that there is a change in any of the information presented in the application, I will promptly notify the Great Lakes Hemophilia Foundation.

In the event that I am awarded program assistance, I am/ am not willing (*check one*) to allow the Great Lakes Hemophilia Foundation to use my name in publicity or promotion of the program. (*Your answer to this question will have no impact on eligibility or award.*)

Signature: _____ Date: _____